MDR Tracking Number: M5-04-2795-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on April 29, 2004.

In accordance with Rule 133.307(d)(1) dates of service 04/23/03 through 04/28/03 were not submitted within the 1-year timeframe and are not within the jurisdiction of Medical Review. Therefore, these dates of service cannot be reviewed.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved.

The office visits, therapeutic exercises, manual traction, myofascial release, and joint mobilization for dates of service 05/07/03 through 07/09/03 were found to be medically necessary.

The hot/cold pack therapy and electrical stimulation for dates of service 05/07/03 through 07/09/03 were not found to be medically necessary.

On July 20, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 19 days of the requestor's receipt of the Notice.

- CPT Code 97110 for date of service 04/30/03 denied as "F". Per the 1996 Medical Fee Guideline, Medicine Ground Rule (I)(A)(9)(b) the submitted relevant information did not clearly delineate exclusive one-to-one treatment. Reimbursement is not recommended.

- CPT Code 97010 (3 units) for dates of service 04/30/03, 05/02/03, and 05/05/03 denied as "F". Per the 1996 Medical Fee Guideline, Medicine Ground Rule (I)(A)(10)(a) reimbursement in the amount of $33.00 ($11.00 x 3) is recommended.

- CPT Code 97032 (6 units) for dates of service 05/02/03, 05/05/03, and 05/09/03 denied as "F". Per the 1996 Medical Fee Guideline, Medicine Ground Rule (I)(A)(10)(a) reimbursement in the amount of $132.00 ($22.00 x 6) is recommended.

- CPT Code 99213 for date of service 05/09/03 denied as "F". Per the 1996 Medical Fee Guideline, Evaluation & Management Ground Rule (VI)(B) reimbursement in the amount of $48.00 is recommended.

The respondent raised no other reasons for denying reimbursement for office visits, therapeutic exercises, manual traction, myofascial release, joint mobilization, hot/cold pack therapy and electrical stimulation.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service **04/30/03** through **07/09/03** in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 9th day of October 2004.

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

MF/mf
Enclosure: IRO decision

NOTICE OF INDEPENDENT REVIEW DECISION

July 16, 2004

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker:
MDR Tracking #: M5-04-2795-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. TMF's health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This patient sustained a work related injury on ___ when he was attempting to lift a heavy wet floor mat when he felt sudden, severe, sharp pain at the right side of his back. The patient was diagnosed as having thoracic and low back strain. The patient was under the care of a chiropractor and received treatment in the form of hot/cold pack therapy, electrical stimulation unattended, level III office visit, therapeutic exercises, traction manual, myofascial release, and joint mobilization that was provided and billed from 05/07/03 through 07/09/03.

Requested Service(s)

Hot/cold pack therapy, electrical stimulation unattended, level III office visit, therapeutic exercises, traction manual, myofascial release, and joint mobilization that was provided and billed from 05/07/03 through 07/09/03.

Decision

It is determined that the level III office visits, therapeutic exercises, traction manual, myofascial release, and joint mobilization provided and billed from 05/07/03 through 07/09/03 were medically necessary to treat this patient's condition. However, passive therapy in the form of hot/cold pack therapy and electrical stimulation during the above time frame was not medically necessary.

Rationale/Basis for Decision

The medical record documentation indicates that the patient was injured on the job on ___ while attempting to lift a heavy wet floor mat. He initially was treated with a few therapy sessions. He continued to experience problems and he sought care at another facility. He was evaluated and a treatment program was begun. National treatment guidelines allow for passive therapy with the progression into active therapy. Such is the situation in this case. Each date of service was sufficiently documented to warrant treatment of his on the job injury. However, there are no treatment guidelines that allow for hot/cold pack therapy or electric stimulation to be utilized approximately four months after the date of the injury.

Sincerely,

Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:vn
Attachment